injury. If the sexual function is retained, not only must the lower half of the conus be preserved, but it must remain connected with the cord above, and the brain.

Minor calls particular attention to the fact that between the second and third sacral segments there occurs a marked change in the microscopic picture. This was first described by Müller. The anterior group of motor cells here disappears and a new group of multipolar cells appears in the region between anterior and posterior horn. The posterior commissure disappears and there is found instead in the medioventral part of the posterior column a sharply-defined bundle of longitudinal fibers which passes into the gray matter and proceeds directly to the region of the intermediate cell group just mentioned.

Further, the pyramidal tracts extend only to the third sacral segment, descending degeneration always disappearing at this point. The region from the third sacral segment caudally forms a special part of the spinal cord which has been called the conus, and lesions confined to this region give a typical clinical picture. In lesions of the region immediately above the third sacral, however, the clinical picture is much more complicated, and it has been thought by some authors impossible to construct one which is typical. This, Minor thinks, is only true for complete transverse lesions, in which case symptoms from the adjoining lower segments are also produced. When a central lesion of the gray matter or of the corresponding roots from the region in question occurs alone, or when the two are combined, the symptoms produced are typical. These Minor gives as two negative and several positive. The negative symptoms are integrity of the sphincters and preserved knee-jerk. The positive symptoms are paralysis in the region of the sacral plexus, in every case the peroneal nerve being most severely and permanently affected. For this region (the fifth lumbar and two upper sacral segments) he proposes the name "Epiconus." As illustrating his views he gives the clinical histories of six cases, in none of which was there an autopsy, however. He also analyzes several cases from other sources. The two articles give an excellent résumé of the subject, but space permits of no more than the outline of them here presented.

ALLEN.

DIAGNOSTIC DIFFERENTIEL DE L'HÉMIPLEGIE ORGANIQUE ET DE L'HÉMIPLEGIE HYSTERIQUE (The Differential Diagnosis of Functional from Organic Hemiplegia). Babinski (Gazz. des. Hôp., Vol. 73, May 5 and 8, 1900, p. 521 *et seq.*).

The author points out that in organic hemiplegia the paralysis is limited to one side of the body, while in hysterical hemiplegia it is not. This observation applies particularly to the face, the paralysis of which in the hysterical form is generally bilateral. In the organic form the paralysis is not systematic. If, for example, one side of the face is profoundly paralyzed, the weakness remains quite evident during the bilaterally-associated movement of the face, but in the functional the paralysis is usually systematic. For while the unilateral movements of the face may be completely abolished, the facial muscles on the paralyzed side act well during the bilateral movements. In the organic there is muscular hypotonicity, principally at the beginning, which is shown in the upper limb by the exaggerated flexion of the forearm. In the functional form there is no hypotonicity; when there is, for example, facial asymmetry, it is due to spasm of the one side. The periosteal and tendon reactions are either abolished, diminished, or increased at the beginning in the organic, and later they are nearly always exaggerated with ankle clonus; but in the functional form these deep reflexes are unaltered, and there is no ankle clonus. In the organic hemiplegia the skin reflexes are generally altered; the abdominal and cremasteric are usually weakened or abolished; the movement of the toes on eliciting the plantar reflex is one of extension; in the functional hemiplegia the cutaneous reflexes are unaffected, and the plantar reflex is the normal flexor response. The character of the contracture in the organic paralysis could not be reproduced by a voluntary contraction of the muscles while in the functional paralysis it well might. The evolution of the organic hemiplegia is regular; contracture follows flaccidity; improvement is progressive, and the paralysis does not fluctuate, now better, now worse. In the functional paralysis the evolution is capricious; the paralysis may remain indefinitely flaccid, or it may even be spasmodic at the beginning. The paralysis is variable in degree and in form, and there may be actual remissions. JELLIFFE.

LE SYNDROME MIGRAINE OPHTHALMOPLEGIQUE COMME PREMIÈRE MANIFESTATION DANS UN CAS DE SYPHILIS CÉRÉBRALE (Ophthalmoplegic Migraine, an early Manifestation of Cerebral Syphilis). H. M. Lamy (Bull. de la Soc. Méd. des Hôpitaux, Vol. xvii, 1900, Dec. 14, p. 1,188).

A woman, aged twenty-six years, had violent migraine two months following confinement. The pains were chiefly localised in the orbital regions, and were accompanied by nausea and vomiting. Both sides were attacked alternately but the pain was more severe on the right. The eyelids were the seat of intense pain, and during the migraine there was slight ptosis on the side involved, which appeared with the commencement of the headache, and generally lasted for some hours. During one attack the patient lost consciousness. Upon recovery the migraine had vanished. Afterwards she was without pain for fifteen days. The attacks then reappeared, were more frequent and severe, and became distinctly unilateral. Ptosis of the right lid followed and continued for a month; later there was double ptosis for five days, but only that on the right side was permanent. Finally, the hemicrania alternated with remarkable regularity, and always became worse during the evening, rendering sleep impossible.

Six months after the onset there was complete right ptosis, and the right pupil was dilated and responded only feebly to light. The left eye was normal. There was loss of memory, the gait was somewhat hesitating and uncertain, and the patient complained of persistent nausea. Although no syphilitic history was obtained cerebral syphilis was diagnosed and energetic treatment adopted. After giving mercury and iodide for a few days the headache and ptosis disappeared and the memory improved. When discharged from hospital the patient neglected treatment and the migraine returned. Resumption of medication ameliorated the condition, but the right pupil became permanently dilated and the opposite external rectus paralyzed.

The unilateral ptosis and the later implication of the sixth nerve together with the other symptoms, indicated something more than simple or periodic migraine. If no organic lesion was present, localised arterial spasms are suggested as explaining the intermittent and alternate paralyses. JELLIFFE.